TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Igor Rakovchik DO

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-17-1462-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
January 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $963.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed the CPT codes 9924[sic], 95886, and 95911, all of which have now been paid in full. Please see the attached EOB and proof of payment via electronic check. These three codes should be dropped from this dispute due to the payment. The supplies used during the EMG/NCV were billed using CPT code A4556 and A4215. Separate payment is not owed for these supplies as they are considered bundled with the services performed by Requestor."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2016	99204, 95886, 95911, A4556, A4215	$963.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the rule that applies to reimbursement?
2. Are supplies separately payable?
3. Is the requestor due additional reimbursement?

Findings

1. The requestor is seeking $963.88 for professional medical services rendered on September 6, 2016.

   The insurance carrier submitted evidence of payment in the amount of $931.98 on January 12, 2017.

   28 Texas Administrative Code §134.203 (c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The maximum allowable reimbursement is calculated as follows:

Submitted Code	Submitted Charge	Allowable	MAR = DWC Conversion Factor / Medicare Conversion Factor) x Allowable	Insurance Paid
99204	$263.13	$167.86	56.82/35.8043 x $167.86 = $266.39	$263.13
95886	$294.32	$93.26	56.82/35.8043 x $167.86 = $148.00 x 2 units = $296.00	$294.32
95911	$374.53	$237.57	56.82/35.8043 x $237.57 = $377.01	$374.53
			Total	$931.98

28 Texas Administrative Code §134.203 (h) states,

> When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
>
> (1) MAR amount;
>
> (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or
>
> (3) fair and reasonable amount consistent with the standards of §134.1 of this title.

The health care provider's usual and customary charge for these services is $931.98. The carrier paid $931.98 no additional payment is due for Codes 99204, 95886, 95911.

2. The remaining codes in dispute are;
   - A4556 - Electrodes (e.g., apnea monitor), per pair. Status Code – P – Bundled/Excluded Codes
   - A4215 – Needle, sterile, any size, each. Status Code X – Statutory Exclusion

28 Texas Administrative Code §134.203 (5) states,

> Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

The applicable Medicare payment policy values Code A4556 and A4215 as bundled or excluded codes. The carrier's denial of 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" is supported.

3. The total allowable for the services in dispute is $931.98. The carrier paid $931.98. No additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 16, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.